



**President**

**Mike Murphy,**  
Anthem Blue Cross Blue  
Shield

**Secretary**

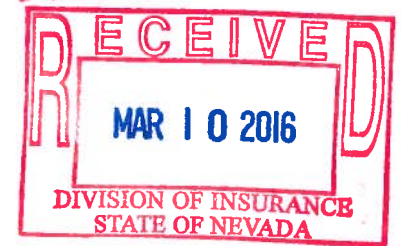
**Shirste Gessler,**  
Anthem Blue Cross Blue  
Shield

**Treasurer**

**Erin Russell,**  
United Healthcare

March 10, 2016

Nevada Division of Insurance  
1818 East College Parkway, Suite 103  
Carson City, NV 89706



Commissioner Richardson,

This letter is in response to the Revised Proposed Regulation of the Commissioner of Insurance, LCB File No. R049-14, October 19, 2015 (Updated by DOI on 2 March 2016). This revised version makes significant and fundamental changes to the proposed network adequacy regulation. Among other things, it fundamentally redefines the definition of "network plan," and creates further ambiguity as to how network adequacy is determined by abjectly throwing away standards that were previously developed with input from the public through the Commissioner's authority to promulgate regulations. The March 2, 2016 version also deletes provisions that would be beneficial to consumers that would require insures to inform members when contracts have been terminated thereby placing consumers at risk for paying billed charges to noncontracted providers.

In addition, the revised version is overtly beneficial to providers without taking into consideration the potential negative impact that the regulation will have on Nevadans. We have previously expressed the concern either through our Association or through our member plans that any limitations on payers ability to negotiate lower prices with providers makes it more likely that individuals and small businesses in many parts of Nevada will not have affordable health insurance options. We believe that the greatest impact will be in rural and frontier Nevada, but counties that contain urban centers may also not have sufficient access to health insurance options in the individual and small group markets.

**Member Companies**

- Aetna
- Anthem Blue Cross Blue Shield
- Hometown Health
- Prominence Health Plan
- United Healthcare
- Universal Health Services

Additionally, this revised version is a step towards "any willing provider," eroding an insurer's ability to negotiate lower prices with and credential providers, likely increasing health care costs for Nevadans. It is worrisome that these changes are made without placing any real responsibility on providers. Indeed, the Division currently has no authority to regulate providers who refuse to contract with payers and charge outrageous prices to consumers. By placing obligations solely on payers providers will be placed in a superior bargaining position to demand higher payments without regard to whether such payments are reasonable or justified.

We respectfully urge the Commissioner to keep in mind the most important constituency - Nevada consumers. While network access and adequacy is an admirable goal, unless consumers have access to affordable health care in a way that protects them from provider lawsuits and bankruptcy, access and adequacy are meaningless. Therefore, in order to ensure that carriers retain the ability to negotiate reasonable rates with providers, we suggest that the DOI consider adopting language from Sections 6 and 7 of the NAIC Health Plan Network Access and Adequacy Model Act. This would help balance the burdens and responsibilities between insurer and provider and also protect patients from being balanced billed or sued by the provider.

Comments regarding specific sections are provided below:

We are concerned about amendments to definitions. It deletes essential definitions (See, for instance, "Network Plan," "Established Patterns of Care," Section 8 of October 19, 2015, version) and "Reasonable Travel," Section 16 of October 19, 2015, version), all of which should be included in the Regulation. The amendment to the definition of Network Plan in particular fundamentally rewrites the definition. Network Plan is no longer defined as "the area in which the plan can be offered," but instead is "the Plan's geographic area approved by the commissioner." Consider for example the prior version of the regulation allowed issuers to take into account the ability to contract with providers or the availability of telehealth providers under Section 22 (these provision has since been deleted). Because of these amendments to definitions and amendments to what the Commissioner may consider in order to determine if a Plan is adequate, the Commissioner (and issuers) may find it more difficult to ensure a sufficient number of plans are offered in areas underserved by providers and actually decrease access. In other words, Network Adequacy may become a barrier to the ability to offer coverage, and actually increase costs.

Because of this we are also very concerned about the deletion of standards the Department may use to determine Network Adequacy under Section 22. To the extent the Department seeks to impose general standards used for the evaluation of Network Adequacy, those standards should be included. Otherwise, the standards imposed on Network Plans will continue to be ambiguous, and deferring the decision to the Network Adequacy Council is likely to only defer the issue. Therefore, we ask that Section 22 of the prior version be added back in.

The proposed Regulation imposes time frames on insurers that do not take into account the practicalities of the business/internet world. For instance, changing from 60 to 45 days the time in which to submit a corrective action plan, (Section 24 of March 2, 2016, version) while ignoring insurers' continued suggestion that the 3 day time frame in which to update their provider of health care directory (Section 22.2 of March 2, 2016, version), deserve a deferral to the insurers' business models.

Under Sec. 22 (1), related to the provider directory, we request the removal of the requirement that insurers shall indicate each provider which has left the network. The provider directory serves a vital role for members to determine what providers are in the plan. Presently, providers that have left the network are removed from the provider directory. A provision that continues to require insurers to list providers that have left the network could be confusing to members and can be overly burdensome on an insurer.

Section 17 creates the Network Adequacy Advisory Council, consisting of nine persons with representation from carriers, providers and consumers. The Association recommends that no fewer than 4 members represent the carriers; that staggered terms of 3 years be set; and, in the event of a vacancy, the vacancy be filled by someone from the same representation group. In addition, we recommend that the Commissioner be required to subject any substantive changes to Network Adequacy regulations or standards to the notice and comment review process in order to ensure the integrity of the regulatory review process. This would require that the Commissioner provide the public notice and the opportunity to comment on any substantive changes. Otherwise, the public will have no opportunity to participate in the regulatory process and the public interest could be harmed.

In addition to the foregoing general comments, the Association recommends the following specific additions to currently proposed provisions (blue is proposed language):

Section 19.2. The Council may, but is not required to, include in the recommendation: (a) Other provider types if their services are required by applicable state or federal law, and (b) *Where available, a number of community providers greater than the minimum percentage required by CMS for qualified health plans and the essential community provider is willing to enter into a letter of agreement with the carrier.*

Section 19. 4. The Commissioner shall decide what action to take on the recommendation by October 1 of each year *to be applicable to the plan year that begins 15 months after the Oct 1 recommendation of the Commissioner.*

Section 21. A carrier who applies to the Commissioner for the issuance of a network plan shall, in conjunction with its annual rate filing, submit in a format determined by the Commissioner, *sufficient data and documentation to establish that its proposed network plan meets the requirements as propounded by the Commissioner in the last preceding October 1 deadline.*

We also suggest that the DOI create an annual list, by zip code where the network adequacy standards cannot be met because there is a lack of providers or providers' charges in those areas are so high that it would be irresponsible for carriers to contract with them. This information would provide Nevadans with a better understanding of why insurance coverage in the individual and small group market is not available in their area or why insurance in particular areas costs significantly more than others.

In summary, the Nevada Association of Health Plans opposes the March 2, 2016, version of the Network Adequacy and suggests that, while the October 19, 2015, is not perfect, it is far preferable to the current iteration. However, if the March 2, 2016 version is going forward, then the Association urges the Commissioner to adopt the changes proposed in this letter—specifically, reinsert deleted Sections 22

and 23 from the October 19 version; adopt versions of Sections 6 and 7 of the NAIC Health Plan Network Access and Adequacy Model Act; reinsert the deleted definitions; recognize telehealth as modality to meet network adequacy requirements; remove the provider directory requirement for providers that have left the network; and the changes in blue above to those sections.

Sincerely,

A handwritten signature in blue ink that reads "Mike Murphy". The signature is written in a cursive, flowing style.

Mike Murphy, President